

EVANGEL CHRISTIAN SCHOOL
14836 Ashdale Avenue, Dale City, Virginia 22193

Athletic Participation/Parental Consent/Physical Examination Form

A separate examination is required for each school year May 1 of the current year through June 30 of the succeeding year.

For School Year _____ **PART I – ATHLETIC PARTICIPATION** Male _____
(To be filled in and signed by the student) Female _____

Name _____ Social Security # _____
(Last) (First) (Middle Initial)

Home Address _____

City/Zip Code _____

Date of Birth _____ Place of Birth _____

Eligibility to participate in interscholastic athletics is a privilege. As a privilege, participation is governed by standards established by Evangel Christian School and implemented by the Athletic Director and coaches. In addition to adhering to school stipulations, there is a higher expectation that these stipulations will be embraced by the athletes who formally represent Evangel Christian School when they wear athletic uniforms.

Additionally, I give my consent and approval for my picture and name to be printed in any Evangel Christian School program, publication or video.

Student Signature _____ Date _____

PART II --MEDICAL HISTORY

This form must be completed by parent or guardian prior to the physical examination and should be taken with the physical examination form for review by the physician during the examination.

YES	NO	
___	___	1. Have you ever had any of the following? Please explain any YES answers.
___	___	heart murmur _____
___	___	high blood pressure _____
___	___	other heart problems _____
___	___	broken bones _____
___	___	weak joints-ankles, knees _____
___	___	concussion _____
___	___	operation _____
___	___	seizures or epilepsy _____
___	___	2. Have you ever fainted or passed out? _____
___	___	3. Have you ever been knocked out? _____
___	___	4. Have you ever been hospitalized? _____
___	___	5. Have you ever had to stop running after ¼ to ½ miles for chest pain or shortness of breath? _____
___	___	6. A. Have you ever had significant allergies to:
___	___	bee stings? - On medication – yes__ no__
___	___	foods _____
___	___	medicine _____
___	___	others _____
___	___	B. Do you have prescription for use of:
___	___	Adrenaline _____
___	___	Inhalers _____
___	___	Other allergy medicine _____
___	___	C. Do you have asthma? _____
___	___	7. Do you take any medicine regularly? _____
___	___	8. Have you had any illnesses lasting a week or more such as mononucleosis, etc.? _____
___	___	9. Have you had any blood disorders, including sickle cell trait, anemia, etc.? _____
___	___	10. Has any family member had a heart attack, heart problems or sudden death before the age of 50? _____
___	___	11. Do you wear contact lenses, eyeglasses or dental appliance? _____
___	___	12. Do you have any missing or non-functioning organs such as testes, eye, kidney, etc.? _____
___	___	13. Menstrual History:
___	___	Have you begun menses yet? _____
___	___	14. Do you have any other significant health problems? _____
___	___	15. Hepatitis B Immunization Series? _____
___	___	16. DATE OF LAST TETNUS IMMUNIZATION? _____

Parent/Guardian
Signature _____

PART III -- PHYSICAL EXAMINATION
(To be completed and signed by examining physician)

NAME _____

HEIGHT _____ WEIGHT _____ SEX _____ AGE _____

*Tanner Stage or Maturation Index _____ BP _____

*Percent Body Fat _____ *Pulse (rest) _____
(Exercise) _____
(Recovery) _____

*Vision: Corrected (L) _____ (R) _____ Both _____
Uncorrected (L) _____ (R) _____ Both _____

*Audiogram _____ Cervical spine/neck _____

Back _____

Eyes _____ Shoulders _____

Ears _____ Arm/elbow/wrist/hand _____

Nose _____ Knees/hips _____

Throat _____ Ankles/feet _____

Teeth _____

Skin _____

Lab

Lymphatic _____ *Urine _____

Lungs _____ *Hemoglobin or HCT _____

Heart _____ and/or Fe Stores _____

Abdomen _____

Genitalia/hernia _____

Peripheral pulses _____ *WHEN MEDICALLY INDICATED

I have reviewed the data above, reviewed his/her medical history form and make the following recommendations for his/her participation in athletics.

_____ Full Participation _____ Limited Participation
_____ No Participation _____ Needs Additional Evaluation

If not recommending full participation, give reasons & recommendations:

Any recommendations or concerns on such items as:

- a. Weight loss or gain or restrictions of weight loss: _____
- b. Slow and careful monitoring of conditioning because of being overweight or show an abnormal exercise testing: _____
- c. Other _____

Physician Signature _____, M.D.* Date _____

*Doctor of Medicine, Doctor of Osteopathy or Licensed Nurse Practitioner

Physician Name (print) _____

Address _____

City/Zip Code _____ Telephone Number _____

PART IV -- ACKNOWLEDGEMENT OF RISK AND INSURANCE STATEMENT

(To be completed and signed by parent/guardian)

I give permission for _____(name of student) to participate in any of the following sports that are not crossed out: baseball, basketball, cheerleading, soccer, volleyball.

I have reviewed and understand the individual eligibility rules and I am aware that with the participation in sports comes the risk of injury to my child/ward. I understand that the degree of danger and the seriousness of the risk varies significantly from one sport to another with contact sports carrying the higher risk. I have had an opportunity to understand the risk inherent in sports through meetings, written handouts, or some other means. He/she has student accident insurance available through the school (yes no); is insured by our family policy with:

Name of Company: _____

Policy Number: _____ Name of Policy Holder: _____

I am aware that participating in sports will involve travel with the team. I acknowledge and accept the risks inherent in the sport and with the travel involved and with this knowledge in mind, grant permission for my child/ward to participate in the sport and travel with the team.

By this signature, I hereby consent to allow the physician(s) and other health care provider(s) selected by myself to perform a pre-participation examination on my child and to provide treatment for any injury or condition resulting from participating in athletics/activities for his/her school during the school year covered by this form. I further consent to allow said physician(s) or health care provider(s) to share appropriate information concerning my child that is relevant to participation in athletics and activities with coaches and other school personnel as deemed necessary.

Additionally I give my consent and approval for the above named student's picture and name to be printed in any high school athletic program, publication or video.

Signature of parent
Or guardian _____ Date _____

Relationship to student _____

PART V - EMERGENCY PERMISSION FORM
(To be completed and signed by parent/guardian)

STUDENT'S NAME _____ GRADE _____ AGE _____

Please list any significant health problems that might be significant to a physician evaluating your child in case of an emergency

Please list any allergies to medications, etc. _____

Has student been prescribed an inhaler or epipen? _____

Is student presently taking medication? _____ If so, what type? _____

Does student wear contact lenses? ___ Please list date of last tetanus shot _____

EMERGENCY AUTHORIZATION: In the event I cannot be reached in an emergency, I hereby give permission to physicians selected by the coaches and staff of Evangel Christian School to hospitalize, secure proper treatment for and to order injection and/or anesthesia and/or surgery for the student named above.

Daytime phone number (where to reach you in emergency) _____

Evening time phone number (where to reach you in emergency) _____

Signature of parent
Or guardian _____ Date _____

Relationship to student _____

*Emergency Permission Form may be reproduced to travel with respective teams and is acceptable for emergency treatment if needed.

I certify all the above information is correct.

Parent/Guardian Signature